SERFF Tracking Number:	*BFLI-126620667*	*State:*	*Arkansas*
Filing Company:	*Bankers Fidelity Life Insurance Company*	*State Tracking Number:*	*46097*
Company Tracking Number:	*AR B 0114 PRF AP2010X3*		
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*Combination Applications*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Bankers Fidelity Life Insurance Company

Product Name: Combination Applications	SERFF Tr Num: BFLI-126620667	State: Arkansas
TOI: MS09 Medicare Supplement - Other 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 46097
Sub-TOI: MS09.000 Medicare Supplement Other 2010	Co Tr Num: AR B 0114 PRF AP2010X3	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Jill Jones, Bridgett Williams, Tina Cunningham, Lyn Ezell, Sharon White, Ron Crow	Disposition Date: 07/19/2010
	Date Submitted: 06/30/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 06/18/2010
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/19/2010	Explanation for Other Group Market Type:
	State Status Changed: 07/19/2010
Deemer Date:	Created By: Jill Jones
Submitted By: Tina Cunningham	Corresponding Filing Tracking Number:

Filing Description:

These applications will be used to underwrite our individual Medicare Supplement and life insurance products, as well as our Short-Term Care nursing facility confinement policy.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*BFLI-126620667*	*State:*	*Arkansas*
Filing Company:	*Bankers Fidelity Life Insurance Company*	*State Tracking Number:*	*46097*
Company Tracking Number:	*AR B 0114 PRF AP2010X3*		
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*Combination Applications*		
Project Name/Number:	*/*		

Tina Cunningham, Compliance Analyst L1 tcunningham@atlam.com
4370 Peachtree Road NE 404-266-5723 [Phone]
Atlanta, GA 30319 404-926-4092 [FAX]

Filing Company Information

Bankers Fidelity Life Insurance Company | CoCode: 61239 | State of Domicile: Georgia
4370 Peachtree Rd NE | Group Code: 587 | Company Type: Life & Health
Atlanta, GA 30319 | Group Name: 61239 | State ID Number:
(404) 266-5600 ext. [Phone] | FEIN Number: 58-0658963

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	$25.00 per form @ 2 forms
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Bankers Fidelity Life Insurance Company	$50.00	06/30/2010	37662983
Bankers Fidelity Life Insurance Company	$50.00	07/02/2010	37717343

SERFF Tracking Number:	*BFLI-126620667*	*State:*	*Arkansas*
Filing Company:	*Bankers Fidelity Life Insurance Company*	*State Tracking Number:*	*46097*
Company Tracking Number:	*AR B 0114 PRF AP2010X3*		
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*Combination Applications*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	07/19/2010	07/19/2010

SERFF Tracking Number:	*BFLI-126620667*	*State:*	*Arkansas*
Filing Company:	*Bankers Fidelity Life Insurance Company*	*State Tracking Number:*	*46097*
Company Tracking Number:	*AR B 0114 PRF AP2010X3*		
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*Combination Applications*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/19/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BFLI-126620667*	*State:*	*Arkansas*
Filing Company:	*Bankers Fidelity Life Insurance Company*	*State Tracking Number:*	*46097*
Company Tracking Number:	*AR B 0114 PRF AP2010X3*		
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*Combination Applications*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Statement of Variability	Accepted for Informational Purposes	Yes
Form	Application for Insurance - Preferred Underwriting Class	Approved	Yes
Form	Application for Insurance - Standard Underwriting Class	Approved	Yes

SERFF Tracking Number:	*BFLI-126620667*	*State:*	*Arkansas*
Filing Company:	*Bankers Fidelity Life Insurance Company*	*State Tracking Number:*	*46097*
Company Tracking Number:	*AR B 0114 PRF AP2010X3*		
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*Combination Applications*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: B 0114 PRF AP2010X3

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 07/19/2010	B 0114 PRF AP2010X3	Application/ Enrollment Form	Application for Insurance - Preferred Underwriting Class	Initial		58.990	B 0114 PRF AP2010X3 doe.pdf
Approved 07/19/2010	B 0115 STND AP2010	Application/ Enrollment Form	Application for Insurance - Standard Underwriting Class	Initial		61.030	B 0115 STND AP2010 doe.pdf

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, GA 30348-5146

APPLICATION FOR INSURANCE
PREFERRED UNDERWRITING CLASS

PLEASE PRINT

Agent/Broker Name		
Jobby Agent		
Agent # Med. Supp	**Agent # Whole Life**	**Agent # Short-Term Care**
00001	00001	00001

Proposed Insured	Social Security No.	Sex	Place (State) of Birth	Age	Born Mo.	Born Day	Born Yr.	Height Ft.	Height In.	Weight Lbs.
John D. Doe	000000001	M	CA	65	06	01	45	6	2	180

Residence Address (Street or Route & Box No.)	City	County	State	Zip Code
#1 Main Street	City	Co	ST	30000-0001

Telephone Number	Best Time to Call:	Proposed Insured E-mail Address:	Mail Policy To:
(123)456 7890	☑ AM ☐ PM 8	johndoe@email.com	☑ Insured ☐ Agent

PRINT—To whom should premium notices be sent? ☑ Same address as Proposed Insured, or:

Payor name _____ Phone number ( )

Complete Address: _____

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

MEDICARE SUPPLEMENT PLANS*:

☐ A ☐ C ☑ F ☐ High Deductible F ☐ G ☐ K

*Some plans not available in all states.

Open Enrollment:

(a) Is the Proposed Insured eligible for coverage under the "Open Enrollment" period (the six month period beginning with the first month in which the Proposed Insured is both age 65 or older and enrolled in Medicare Part B)? ..... ☑ Yes ☐ No

(b) Is the Proposed Insured eligible for coverage under the 63-day (90-days in WY only) "guarantee issue" period ? ..... ☐ Yes ☑ No
If "Yes," proof must be submitted.

MEDICARE SUPPLEMENT MODAL PREMIUMS—choose one column:

	with Household Discount	without Household Discount
Monthly Bank Draft Premium	$ xxx.xx	$
5% Household Discount if qualified	x .95	N/A
equals Monthly Bank or Credit Card Premium	= $ xxx.xx	$
Other Modes: EITHER multiply by modal factor	x	
OR if Monthly Direct Bill add $2 service fee	+ $	$
Total Intial Premium Due	= $ xxx.xx	$

*If the Proposed Insured does not qualify for the Household Discount, the full modal premium will be required.

SHORT-TERM CARE*:

*Not available in KS, ND, OR, SD,TX or WA

Daily Benefit: $ 200.00

minimum $20**–maximum $200 **$30 in GA

Benefit Period (days): ..... ☐ 180 ☑ 360

Inflation Rider: ..... ☑ Yes ☐ No

PREMIUM CLASS:

☑ Non-Tobacco* ☐ Tobacco**

*Has not used any tobacco product in the last 3 years.

**Medicare Supplement applicants qualified for open enrollment or 63-day guarantee issue will automatically be given Non-Tobacco rates.

Medicare Supplement applicants who are not qualified for open enrollment or 63-day guarantee issue and have used tobacco products in the last 3 years are not eligible for Preferred rates.

PREMIUM MODE:

☐ Annual ☐ Monthly Direct*

☐ Semi-Annual ☑ Monthly Bank Draft**

☐ Quarterly ☐ Monthly Credit Card**

*Not available on Life

**Requested Draft Date 1st

LIFE INSURANCE*:

☑ Level Whole Life

☐ Endowment at Age 100

Requested Face Amount $ 30,000.00

Automatic Premium Loan: ..... ☑ Yes ☐ No

*Includes Accelerated Death Benefit Rider and Waiver of Premium Rider.**

**Waiver of Premium not available in KS or SC

BILLING TYPE:

☑ Individual ☐ Family*

*Complete Family Billing Form B 0129 FB/LB

REQUESTED EFFECTIVE DATE:

Medicare Supplement: 06-01-10

Life Insurance: 06-01-10

Short-Term Care: 06-01-10

INITIAL PREMIUM COMPUTATION:

Medicare Supplement	$ xxx.xx
Short-Term Care	$ xxx.xx
One-Time Policy Fee	$ xx.xx
Life Insurance	$ xxx.xx
Modal Policy Fee	$ xx.xx
Total Amount Paid	$ xxx.xx

☑ Check/money order included

☐ Charge credit card for initial premium

☐ Draft initial premium* *Initial Draft Date _____

HOUSEHOLD DISCOUNT* INFORMATION—PLEASE ANSWER BOTH QUESTIONS 1 AND 2 IN THIS SECTION.

1. The Proposed Insured has continuously resided with another person for the last 12 months and the other person is also applying for this coverage. ..... ☑ Yes ☐ No
   If "yes" please complete the information regarding relationship to applicant below.
2. The Proposed Insured has continuously resided with another person for the last 12 months and the other person has an existing Medicare Supplement policy with Bankers Fidelity Life Insurance Company..... ☐ Yes ☑ No
   If "yes" please complete the information regarding relationship to the Proposed Insured below.
3. Name: Jane D. Doe
   Relationship to Applicant: ☑ Spouse ☐ Sibling ☐ Other: _____
   ☑ Application Pending or Existing Policy Number: _____

* If the Proposed Insured does not qualify for the Household Discount, the full modal premium will be required. The discount is applicable to the Medicare Supplement policy ONLY.

(Application continued on next page)

MEDICARE SUPPLEMENT

4. (a) Medicare claim number 000-00-0001-AB *(Record full, complete number from Medicare card.)*

(b) Is the Proposed Insured covered under Medicare Part A? ☑ Yes ☐ No **If "Yes," effective date** 06-01-10

(c) Is the Proposed Insured covered under Medicare Part B? ☑ Yes ☐ No **If "Yes," effective date** 06-01-10

(d) Is the Proposed Insured covered under Social Security Disability? ☐ Yes ☑ No **If "Yes," effective date** _____

5. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X" to the best of your knowledge.

(A) Did you turn age 65 in the last 6 months? ☑ Yes ☐ No

(B) Did you enroll in Medicare Part B in the last 6 months? ☑ Yes ☐ No

(C) If yes, what is the effective date? 06-01-10

(D) Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) ☐ Yes ☑ No

(a) If yes, will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☑ No

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☑ No

(E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (90 days in WY) (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☑ No

(b) Was this your first time in this type of Medicare plan? ☐ Yes ☑ No

(c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ Yes ☑ No

(F) Do you have another Medicare supplement policy in force? ☐ Yes ☑ No

(a) If so, with what company, and what plan do you have? _____

(b) If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☑ No

(G) Have you had coverage under any other health insurance within the past 63 days? (90 days in WY) (for example, an employer, union or individual plan) ☐ Yes ☑ No

(a) If so, with what company and what kind of policy? _____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.
Start date _____ End Date _____

LIFE & SHORT-TERM CARE

ANSWER THE FOLLOWING QUESTION IF APPLYING FOR LIFE INSURANCE OR SHORT-TERM CARE:

6. Is the Proposed Insured a legal citizen of the United States or its possessions? ☑ Yes ☐ No

If "No," is the Proposed Insured a Permanent Resident? ☐ Yes ☐ No **If "No," coverage is not available.**

If "Yes," provide the following information as shown on the Permanent Resident Card:

I.N.S. # _____ CATEGORY _____ RESIDENT SINCE _____ CARD EXPIRES _____

7. **PRESENT INSURANCE:** Does the Proposed Insured have any life, annuity, medical, health, nursing facility or long-term care insurance currently in force or pending with any company? ☐ Yes ☑ No

List all life or health insurance now in force and indicate which coverage is to be replaced:

Name of Company	Policy No.	Type of Policy	Coverage To Be Replaced?	Termination Date Mo.–Yr.
			☐ Yes ☐ No	
			☐ Yes ☐ No	

LIFE

8. Name of Primary Beneficiary(ies)	Relationship	Social Security No. *(If known)*	Address	Telephone No.
Jane D. Doe	wife	000-00-0002	same	same
Name of Contingent Beneficiary(ies)	Relationship	Social Security No. *(If known)*	Address	Telephone No.
John D. Doe Jr.	son	000-00-0003	same	same
Name of Payor *(If other than Insured)*	Relationship	Social Security No. *(If known)*	Address	Telephone No.
Name of Owner *(If other than Insured)*	Relationship	Social Security No. *(If known)*	Address	Telephone No.

(Application continued on next page)

SHORT-TERM CARE

ANSWER THE FOLLOWING QUESTIONS IF APPLYING FOR SHORT-TERM CARE: (not available in KS, ND, OR, SD, TX or WA)

9. (a) Is the Proposed Insured currently covered under Medicaid? ..... ❑ Yes ☑ No
   (b) Within the last 5 years, has the Proposed Insured received disability payments from Social Security or Medicaid? ..... ❑ Yes ☑ No
   If "Yes," reason(s) for disability _____

ALL APPLICANTS: IF THE ANSWER TO ANY PART OF QUESTION 10 – 13 IS "YES," COVERAGE IS NOT AVAILABLE. IF ELIGIBLE FOR OPEN ENROLLMENT OR 63-DAY (90 DAYS IN WY ONLY) GUARANTEE ISSUE, DO NOT ANSWER QUESTIONS 10 – 16.

10. In the past 5 years, has the Proposed Insured had or been medically diagnosed with or treated for:
    (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? ..... ❑ Yes ☑ No
    (b) any lipidosis, including Gaucher's or Tay-Sachs or Wolman's? ..... ❑ Yes ☑ No
11. In the past year, has the Proposed Insured:
    (a) been confined to a hospital 2 or more times or to a nursing facility, or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring or toileting? ..... ❑ Yes ☑ No
    (b) been confined to a wheelchair or require the use of a wheelchair or motorized mobility aid due to a medical condition or on the advice of a physician? ..... ❑ Yes ☑ No
    (c) been medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? ..... ❑ Yes ☑ No
    (d) had any heart or circulatory surgery? ..... ❑ Yes ☑ No
12. In the last 3 years, has the Proposed Insured had, been medically diagnosed with, or treated for:
    (a) heart attack, stroke of any kind, congestive heart failure, or amputation due to disease? ..... ❑ Yes ☑ No
    (b) cirrhosis, liver disease, or hepatitis (excluding Type A)? ..... ❑ Yes ☑ No
13. In the past 5 years, has the Proposed Insured had, been medically diagnosed with, or treated for:
    (a) emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, or used supplemental oxygen? ..... ❑ Yes ☑ No
    (b) internal cancer, leukemia, malignant melanoma, Hodgkin's disease, kidney/renal failure or insufficiency, chronic kidney disease, or been advised to have or had dialysis? ..... ❑ Yes ☑ No
    (c) Alzheimer's disease, dementia, organic brain syndrome, schizophrenia or delusional or psychotic disorder, alcoholism or drug addiction, or diabetes requiring insulin? ..... ❑ Yes ☑ No
    (d) Parkinson's or Huntington's disease, multiple sclerosis, muscular dystrophy, Lou Gehrig's disease (ALS), systemic lupus, or sickle cell anemia? ..... ❑ Yes ☑ No
    (e) testing or surgery for the transplanting of any organ or tissue (excluding corneal transplants)? ..... ❑ Yes ☑ No
14. Has the Proposed Insured used any tobacco products in the last 3 years? **If "Yes" non-tobacco rates are not available.** ... ❑ Yes ☑ No
15. List all prescription drugs the Proposed Insured is currently taking or has been medically advised to take:
    (If "None," so state; if additional space is needed attach separate page and have Proposed Insured sign and date.)

Medication	Amount	Condition for Which Prescribed	Currently Taking?
none			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

16. Please provide complete name, address and telephone number of the Proposed Insured's primary care physician:
    Physician's name: Dr. Bob Telephone number 123-456-8907
    Physician's address: #1 Healing Lane, City ST 30000

17. **NOTICE TO THE PROPOSED INSURED:** (a) You do not need more than one Medicare supplement policy. (b) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (d) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (e) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

18. I, the undersigned Applicant, hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. **I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated herein.** I have received an outline of coverage and a "*Guide To Health Insurance For People With Medicare.*"

The undersigned Applicant and/or Proposed Insured and agent state that the Applicant and/or Proposed Insured have read or had read to him the completed application and that the Applicant and/or Proposed Insured realize that any false statement or material misrepresentation in the application may result in loss of coverage under the policy(ies), subject to the "Incontestability" and/or "Time Limit On Certain Defenses" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company may have the right to deny benefits or contest your policy, subject to the "Time Limit On Certain Defenses" provision of the Policy.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

☑ I am applying for a Medicare Supplement policy and/or Short-Term Care policy. I have received an outline of coverage and a *"Guide To Health Insurance For People With Medicare"* (if age 65 or older)

☑ I am applying for life insurance. I have received a *"Life Insurance Buyer's Guide."*

Dated at City ST (City and State), on 06-01-10 (Month, Day, Year) X John D Doe (Proposed Insured's signature. Please read item 18 before signing.)

X Joe Agent (Agent's signature) 00001 (Agent's number) X _____ (Applicant's signature, if not Proposed Insured)

WRITING AGENT COMPLETE

Is any of this insurance being purchased to replace or change any existing insurance or annuities?..... ❑ Yes ☑ No

If "YES" which insurance: ❑ Medicare Supplement ❑ Life Insurance ❑ Short-Term Care

Complete Replacement Notice(s) as required.

If the applicant is applying for Medicare Supplement:

I have sold the following health insurance to the Proposed Insured which are still in force: none

I have sold the following health insurance policies to the Proposed Insured within the past 5 years which are no longer in force: none

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare." (if applying for Medicare Supplement or Short-Term Care age 65 or older) and a "Life Insurance Buyers Guide," (if applying for Life Insurance).

I certify that to the best of my knowledge and belief the Medicare Supplement coverage applied for herein does not duplicate coverage the Proposed Insured currently has in force (if applying for Medicare Supplement).

Is the Proposed Insured related to you? ❑ Yes ☑ No If "Yes," explain relationship: ❑ Self ❑ _____

If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insureds identity as required by the USA Patriot Act (PL107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:

☑ Drivers License ❑ Passport ❑ Government-issued identification card ❑ Other _____

Dated at City ST (City and State), on 06-01-10 (Month, Day, Year) X Joe Agent (Agent's signature) 00001 (Agent's number)

X _____ (Co-signature (if required))

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, GA 30348-5146

APPLICATION FOR INSURANCE
STANDARD UNDERWRITING CLASS

PLEASE PRINT

Agent/Broker Name	
Joe Agent	
Agent # Medicare Supplement	Agent # Whole Life
00001	00001

Proposed Insured	Social Security No.	Sex	Place (State) of Birth	Age	Born Mo.	Day	Yr.	Height & Weight Ft.	In.	Lbs.
John D. Doe	000000001	M	GA	65	06	01	45	6	2	180

Residence Address (Street or Route & Box No.)	City	County	State	Zip Code
#1 Main Street	City	Co	ST	30000-0001

Telephone Number	Best Time to Call:	Proposed Insured E-mail Address:	Mail Policy To:
(123) 4567890	8 ☐ AM ☐ PM	johnddoe@email.com	☑ Insured ☐ Agent

PRINT—To whom should premium notices be sent? ☐ Same address as Proposed Insured, or:

Payor name _____ Phone number ( )

Complete Address: _____

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

MEDICARE SUPPLEMENT PLANS*:

☐ A ☐ C ☑ F ☐ High Deductible F ☐ G ☐ K

*Some plans not available in all states.

Open Enrollment:

(a) Is the Proposed Insured eligible for coverage under the "Open Enrollment" period (the six month period beginning with the first month in which the Proposed Insured is both age 65 or older and enrolled in Medicare Part B)? ..... ☑ Yes ☐ No

(b) Is the Proposed Insured eligible for coverage under the 63-day (90-days in WY only) "guarantee issue" period ? ..... ☐ Yes ☐ No
If "Yes," proof must be submitted.

MEDICARE SUPPLEMENT MODAL PREMIUMS—choose one column:

	with Household Discount	without Household Discount
Monthly Bank Draft Premium	$ xxx.xx	$
5% Household Discount if qualified	x .95	N/A
equals Monthly Bank or Credit Card Premium	= $ xxx.x1	$
Other Modes: EITHER multiply by modal factor	x	
OR if Monthly Direct Bill add $2 service fee	+ $	$
Total Initial Premium Due	= $ xxx.x1	$

*If the Proposed Insured does not qualify for the Household Discount, the full modal premium will be required.

LIFE INSURANCE:

☑ Level Whole Life*
☐ Modified Whole Life**

Requested Face Amount $ 20,000.00

Automatic Premium Loan: ..... ☐ Yes ☐ No

* Includes Accelerated Death Benefit Rider and Wavier of Premium Rider.†

† Waiver of Premium not available in KS or SC

** Not available in AR, KS, MD, MO, NC, ND, WA, WV or WI

PREMIUM CLASS:

☑ Non-Tobacco* ☐ Tobacco**

*Has not used any tobacco product in the last 3 years.

**Medicare Supplement applicants qualified for open enrollment or 63-day guarantee issue will automatically be given Non-Tobacco rates.

Medicare Supplement applicants who are not qualified for open enrollment or 63-day guarantee issue and have used tobacco products in the last 3 years are not eligible for Preferred rates.

PREMIUM MODE:

☐ Annual ☐ Monthly Direct*
☐ Semi-Annual ☑ Monthly Bank Draft**
☐ Quarterly ☐ Monthly Credit Card**

*Not available on Life

**Requested Draft Date 1st

BILLING TYPE:

☑ Individual ☐ Family*

*Complete Family Billing Form B 0129 FB/LB

REQUESTED EFFECTIVE DATE:

Medicare Supplement: 06-01-10

Life Insurance: 06-01-10

INITIAL PREMIUM COMPUTATION:

Medicare Supplement..... $ xxx.xx
Life Insurance..... $ xxx.x1
Modal Policy Fee..... $ xx.00
Total Amount Paid ..... $ xxx.x1

☑ Check/money order included
☐ Charge credit card for initial premium
☐ Draft initial premium* *Initial Draft Date _____

HOUSEHOLD DISCOUNT* INFORMATION—PLEASE ANSWER BOTH QUESTIONS 1 AND 2 IN THIS SECTION.

1. The Proposed Insured has continuously resided with another person for the last 12 months and the other person is also applying for this coverage. ..... ☑ Yes ☐ No
   If "yes" please complete the information regarding relationship to applicant below.
2. The Proposed Insured has continuously resided with another person for the last 12 months and the other person has an existing Medicare Supplement policy with Bankers Fidelity Life Insurance Company..... ☐ Yes ☑ No
   If "yes" please complete the information regarding relationship to the Proposed Insured below.
3. Name: Jane D. Doe
   Relationship to Applicant: ☑ Spouse ☐ Sibling ☐ Other: _____
   ☐ Application Pending or Existing Policy Number: _____

* If the Proposed Insured does not qualify for the Household Discount, the full modal premium will be required. The discount is applicable to the Medicare Supplement policy ONLY.

(Application continued on next page)

MEDICARE SUPPLEMENT

4. (a) Medicare claim number 000-00-0001-AB *(Record full, complete number from Medicare card.)*

(b) Is the Proposed Insured covered under Medicare Part A? ☑ Yes ☐ No **If "Yes," effective date** 06-01-10

(c) Is the Proposed Insured covered under Medicare Part B? ☑ Yes ☐ No **If "Yes," effective date** 06-01-10

(d) Is the Proposed Insured covered under Social Security Disability? ☐ Yes ☑ No **If "Yes," effective date** _____

5. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X" to the best of your knowledge.

(A) Did you turn age 65 in the last 6 months? ☑ Yes ☐ No

(B) Did you enroll in Medicare Part B in the last 6 months? ☑ Yes ☐ No

(C) If yes, what is the effective date? 06-01-10

(D) Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) ☐ Yes ☑ No

(a) If yes, will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☑ No

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☑ No

(E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (90 days in WY) (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☑ No

(b) Was this your first time in this type of Medicare plan? ☐ Yes ☑ No

(c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ Yes ☑ No

(F) Do you have another Medicare supplement policy in force? ☐ Yes ☑ No

(a) If so, with what company, and what plan do you have? _____

(b) If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☑ No

(G) Have you had coverage under any other health insurance within the past 63 days? (90 days in WY) (for example, an employer, union or individual plan) ☐ Yes ☑ No

(a) If so, with what company and what kind of policy? _____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.
Start date _____ End Date _____

LIFE

ANSWER THE FOLLOWING QUESTIONS IF APPLYING FOR LIFE INSURANCE:

6. Is the Proposed Insured a legal citizen of the United States or its possessions? ☑ Yes ☐ No
If "No," is the Proposed Insured a Permanent Resident? ☐ Yes ☐ No **If "No," coverage is not available.**
If "Yes," provide the following information as shown on the Permanent Resident Card:

I.N.S. # _____ CATEGORY _____ RESIDENT SINCE _____ CARD EXPIRES _____

7. **PRESENT INSURANCE:** Does the Proposed Insured have any life insurance or annuities currently in force or pending with any company? ☐ Yes ☑ No
List all life insurance now in force and indicate which coverage is to be replaced:

Name of Company	Policy No.	Type of Policy	Coverage To Be Replaced?	Termination Date Mo.–Yr.
			☐ Yes ☐ No	
			☐ Yes ☐ No	

8. Name of Primary Beneficiary(ies)	Relationship	Social Security No. *(If known)*	Address	Telephone No.
Jane D. Doe	wife	000-00-0002	Same	Same
Name of Contigent Beneficiary(ies)	**Relationship**	**Social Security No. *(If known)***	**Address**	**Telephone No.**
John D. Doe Jr	son	000-00-0003	Same	Same
Name of Payor (If othger than Insured)	**Relationship**	**Social Security No. *(If known)***	**Address**	**Telephone No.**
Name of Owner (If othger than Insured)	**Relationship**	**Social Security No. *(If known)***	**Address**	**Telephone No.**

(Application continued on next page)

ALL APPLICANTS: IF THE ANSWER TO ANY PART OF QUESTION 9 or 10 IS "YES," COVERAGE IS NOT AVAILABLE. IF ELIGIBLE FOR OPEN ENROLLMENT OR 63-DAY (90 DAYS IN WY ONLY) GUARANTEE ISSUE, DO NOT ANSWER QUESTIONS 9 – 13.

9. In the past 5 years, has the Proposed Insured had or been medically diagnosed with or treated for:
   (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? ❑ Yes ☑ No
   (b) any lipidosis, including Gaucher's or Tay-Sachs or Wolman's? ❑ Yes ☑ No
10. In the past year, has the Proposed Insured:
   (a) been confined to a hospital 3 or more times or to a nursing facility, or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring or toileting? ❑ Yes ☑ No
   (b) been confined to a wheelchair or require the use of a wheelchair or motorized mobility aid due to a medical condition or on the advice of a physician? ❑ Yes ☑ No
   (c) been medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? ❑ Yes ☑ No
   (d) had any heart or circulatory surgery? ❑ Yes ☑ No

IF THE ANSWER TO ANY PART OF QUESTION 11 IS "YES," MEDICARE SUPPLEMENT AND LEVEL WHOLE LIFE ARE NOT AVAILABLE. ONLY THE MODIFIED WHOLE LIFE MAY BE AVAILABLE. ***Not available in AR, KS, MD, MO, NC, ND, WA, WV or WI**

11. In the last 3 years, has the Proposed Insured had, been medically diagnosed with, or treated for:
   (a) heart attack, stroke (excluding transient ischemic attack (TIA) or mini stroke), congestive heart failure, or amputation due to disease? ❑ Yes ☑ No
   (b) emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, or used supplemental oxygen? ❑ Yes ☑ No
   (c) cirrhosis, liver disease, hepatitis (excluding Type A), kidney/renal failure or insufficiency, chronic kidney disease, or been advised to have or had dialysis? ❑ Yes ☑ No
   (d) internal cancer, leukemia, malignant melanoma, or Hodgkin's disease? ❑ Yes ☑ No
   (e) Alzheimer's disease, dementia, organic brain syndrome, schizophrenia or delusional or psychotic disorder, alcoholism or drug addiction? ❑ Yes ☑ No
   (f) Parkinson's or Huntington's disease, multiple sclerosis, muscular dystrophy, Lou Gehrig's disease (ALS), systemic lupus, or sickle cell anemia? ❑ Yes ☑ No
   (g) diabetic coma, insulin shock or are you taking 70 or more units of insulin daily? ❑ Yes ☑ No
   (h) testing or surgery for the transplanting of any organ or tissue (excluding corneal transplants)? ❑ Yes ☑ No
12. List all prescription drugs the Proposed Insured is currently taking or has been medically advised to take:
   (If "None," so state; if additional space is needed attach separate page and have Proposed Insured sign and date.)

Medication	Amount	Condition for Which Prescribed	Currently Taking?
None			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

13. Please provide complete name, address and telephone number of the Proposed Insured's primary care physician:
   Physician's name: Dr. Bob Telephone number 123-456-8907
   Physician's address: #1 Healing Lane Cure ST 30000

14. **NOTICE TO THE PROPOSED INSURED:** (a) You do not need more than one Medicare supplement policy. (b) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (d) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (e) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

15. I, the undersigned Applicant, hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. **I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated herein.** I have received an outline of coverage and a "*Guide To Health Insurance For People With Medicare.*"

The undersigned Applicant and/or Proposed Insured and agent state that the Applicant and/or Proposed Insured have read or had read to him the completed application and that the Applicant and/or Proposed Insured realize that any false statement or material misrepresentation in the application may result in loss of coverage under the policy(ies), subject to the "Incontestability" and/or "Time Limit On Certain Defenses" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company may have the right to deny benefits or contest your policy, subject to the "Time Limit On Certain Defenses" provision of the Policy.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

☑ I am applying for a Medicare Supplement policy. I have received an outline of coverage and a "*Guide To Health Insurance For People With Medicare*" (if age 65 or older)

☑ I am applying for life insurance. I have received a *"Life Insurance Buyer's Guide."*

Dated at City ST (City and State), on 06-01-10 (Month, Day, Year) X [signature] (Proposed Insured's signature. Please read item 15 before signing.)

X Joe Agent (Agent's signature) 00001 (Agent's number) X _____ (Applicant's signature, if not Proposed Insured)

WRITING AGENT COMPLETE

Is any of this insurance being purchased to replace or change any existing insurance or annuities?..... ❑ Yes ☑ No

If "YES" which insurance: ❑ Medicare Supplement ❑ Life Insurance

Complete Replacement Notice(s) as required.

If the applicant is applying for Medicare Supplement:

I have sold the following health insurance policies to the Proposed Insured which are still in force: none

I have sold the following health insurance policies to the Proposed Insured within the past 5 years which are no longer in force: none

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare." (if applying for Medicare Supplement) and a "Life Insurance Buyers Guide," (if applying for Life Insurance).

I certify that to the best of my knowledge and belief the Medicare Supplement coverage applied for herein does not duplicate coverage the Proposed Insured currently has in force (if applying for Medicare Supplement).

Is the Proposed Insured related to you? ❑ Yes ☑ No If "Yes," explain relationship: ❑ Self ❑ _____

If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insureds identity as required by the USA Patriot Act (PL107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:

☑ Drivers License ❑ Passport ❑ Government-issued identification card ❑ Other _____

Dated at City ST (City and State), on 06-01-10 (Month, Day, Year) X Joe Agent (Agent's signature) 00001 (Agent's number)

X _____ (Co-signature (if required))

SERFF Tracking Number:	*BFLI-126620667*	*State:*	*Arkansas*
Filing Company:	*Bankers Fidelity Life Insurance Company*	*State Tracking Number:*	*46097*
Company Tracking Number:	*AR B 0114 PRF AP2010X3*		
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*Combination Applications*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification — Accepted for Informational Purposes — 07/19/2010

Comments:

Attachments:

Guaranty Association.pdf

Consumer Notice.pdf

B 0114 PRF AP2010X3 Flesch Cert.pdf

Item Status: **Status Date:**

Satisfied - Item: Application — Approved — 07/19/2010

Comments:

Attachment:

AR B 0114 PRF AP2010X3 Forms Use List.pdf

Item Status: **Status Date:**

Bypassed - Item: Health - Actuarial Justification

Bypass Reason: N/A as this is for applications

Comments:

Item Status: **Status Date:**

Bypassed - Item: Outline of Coverage

Bypass Reason: N/A as this filing is for applications.

Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability — Accepted for Informational — 07/19/2010

SERFF Tracking Number:	*BFLI-126620667*	*State:*	*Arkansas*
Filing Company:	*Bankers Fidelity Life Insurance Company*	*State Tracking Number:*	*46097*
Company Tracking Number:	*AR B 0114 PRF AP2010X3*		
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*Combination Applications*		
Project Name/Number:	*/*		

Purposes

Comments:

Attachment:

B 0114 PRF AP2010X3 Statement of Variability.pdf

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are member of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting the insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

The Arkansas Life and Health Insurance Guaranty Association
C/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72202

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not):
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different type of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

BANKERS FIDELITY LIFE INSURANCE COMPANY

Atlanta, Georgia

The following information is being provided to you in accordance with Act 197 of the Arkansas Department of Insurance Regulations:

Bankers Fidelity Life Insurance Company
Policyholder Service Department
4370 Peachtree Road, N.E.
Atlanta, Georgia 30319
Toll-Free: 866-458-7500
Fax: (404) 926-4033
bflphs@atlam.com

If we at Bankers Fidelity Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Department of Insurance
Consumer Service Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
(510) 371-2640, (800) 852-5494
Fax: (501) 371-2749
insurance.consumers@arkansas.gov

Your Agent:
{Fld0240}
{Fld0241} {Fld0242}
{Fld0243} {Fld0244}
{Fld0245}

This notice is for information only and does not become a part or condition of your policy.

BANKERS FIDELITY LIFE INSURANCE COMPANY
Atlanta, Georgia

FLESCH SCORE CERTIFICATION

I hereby certify that the Flesch reading ease score of the above forms is as shown.

B 0114 PRF AP2010X3 - Application

Words:	380
Sentences:	20
Syllables:	623
Score:	*58.99*

B 0115 STND AP2010 – Application

Words:	466
Sentences:	19
Syllables:	666
Score:	*61.03*

Sharon A. White
Vice President; Legal/Compliance

06-08-2010
Date

Application Forms: B 0114 PRF AP2010X3 and B 0115 STND AP2010
POLICY FORMS UNDERWRITTEN

Arkansas

The following policy forms and riders may be solicited:

Form Number	Description / Title	Approved by State
B 21092 A	Medicare Supplement Plan A	03-23-2010
B 21092 F	Medicare Supplement Plan F	03-23-2010
B 21092 F2	Medicare Supplement High Ded Plan F	03-23-2010
B 21092 G	Medicare Supplement Plan G	03-23-2010
B 21092 K	Medicare Supplement Plan K	03-23-2010
B 21092 R1	Household Premium Discount Rider	03-23-2010
B 9305	Short Term Care Nursing Facility Policy	05-16-1995
B 9305 R1 (R06-05)	Simple Interest Inflation Rider	12-28-2005
B 20604	Endowment at Age 100	07-10-2006
B 20801	Level Whole Life Insurance	10-06-2008
B 20802	Graded Death Benefit - Modified Whole Life	12-02-2008
B 20803	Level Whole Life Insurance	10-21-2008
BFL-ADB	Accidental Death Benefit Rider	02-01-1989
BFL-WPD	Waiver of Premium for Disability Rider	02-01-1989
B 0108 WP NHC	Waiver of Premium for Nursing Home Conf.	08-21-1997
B 0109 TI ADB 50	Accelerated Death Benefit Rider	08-15-1997

STATEMENT OF VARIABILITY

Combination Applications

Forms: **B 0114 PRF AP2010X3**
B 0115 STND AP2010

ITEM	VARIABILITY
Checkboxes for Medicare Supplement Plans	ability to remove plans that are no longer offered or offer additional standardized plans that are later approved by the state
References to Household Discount	ability to remove the offering of the Household Premium Discount Rider at a later date if so desired
Checkboxes for Life Insurance	ability to add or remove life insurance plans at a later date